Physician Permission for Swaddling

In order to reduce the risk of Sudden Unexpected Infant Death, including Sudden Infant Death Syndrome, suffocation and other sleep related deaths, Colorado Rules and Regulations for both Family Child Care Homes and Child Care Centers prohibits child care providers from swaddling infants of any age.

Name of Child Care Facility_____ License # _____

Parent Permission:

Child Name _____ Date of Birth ____/____/____

Swaddling: Colorado Rules and Regulations for Family Child Care Homes and Child Care Centers prohibits the use of swaddling including use of any blankets or sleep sacks that prevent or restrict infant movement. I,_____ give consent for my child to be swaddled as indicated by my child's physician. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider.

_____ ____/___/____
Parent or Legal Guardian Signature Date

Physician Permission:

I understand that swaddling is no longer permitted for infants by Rules Regulating Family Child Care Homes and Child Care Centers and I direct the use of swaddling for this infant for the medical reason(s) stated below. By signing this form I am acknowledging that I am directing only the use of a swaddle and that the infant must always be placed in an approved crib for sleep.

The infant named above has the following medical reason(s) which necessitates swaddling:

_____
(attach additional information if necessary)

Specify when infant should be swaddled (i.e. nap time only): _____

Infant rolls from back to stomach ___ yes ___no Infant rolls from stomach to back ___ yes ___ no

Effective dates of Permission: from: ___/___/___ to ___/___/___

Date infant will be re-evaluated for the need for swaddling: ___/____/___

_____ ____/____/____
Physician Signature Date

Office Stamp, or write Name, Address and Phone Number